



**Dr. Nate Greenstein  
Patient General information**

Please complete this general information form. Be as complete and accurate as possible. If something does not apply, put N/A for not applicable.  
*Please print or type.*

Today's Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Legal Name: \_\_\_\_\_  
Last First Middle (Nickname)

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Local Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status:  M  S  W  D or  Separated Sex:  M  F # of children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Ste #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Landlord: \_\_\_\_\_ Phone: \_\_\_\_\_

Who may we contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Who may we thank for referring you to us: \_\_\_\_\_ Phone: \_\_\_\_\_

**Financial Arrangements**

Check appropriate one(s):

- Private Pay (Cash, Check, or Credit Card)
- Individual Health Insurance
- Group Health Insurance
- Medicare
- Automobile Insurance
- Worker's Compensation
- Other \_\_\_\_\_

If insurance coverage:

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

Company Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_

Certificate #: \_\_\_\_\_

Group Name: \_\_\_\_\_

Medicare #: \_\_\_\_\_

Other Type of ID #: \_\_\_\_\_

If accidental injury, do you have an attorney that represents you?  No  Yes

If yes, what is the attorney's name, address and telephone number: \_\_\_\_\_

**Please read, sign and date the following:**

I am ultimately financially responsible for my account even if insurance coverage is available. The information is accurate to the best of my knowledge. I will notify you of any future changes with my general information.

Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_